Author's response to reviews

Title: Occurrence and quality of anticoagulant treatment of chronic atrial fibrillation in primary health care in Sweden: a retrospective study on electronic patient records

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PDF covering letter
Dear Editor,

Attached is a manuscript entitled “Occurrence and quality of anticoagulant treatment of chronic atrial fibrillation in primary health care in Sweden: a retrospective study on electronic patient records “, which we would be pleased if you would reconsider for publication in BMC Clinical Pharmacology.

As far as we can see, we have now fully and successfully addressed the comments from the reviewer Alan Go, as itemised below.

Yours sincerely,

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Revisions and explanations as related to the numbered comments in the reviewer’s report.

Discretionary revision:
A new reference (Hylek EM et al 2003) is added on page 4, paragraph 2, sentence 4.

Minor compulsory revisions (not numbered):
“Effectiveness” is changed to “efficacy” on page 4, paragraph 1, sentence 2.

The number of patients in the population list is changed to 75,146 in the Method section.

In the Results section the second sentence is changed to: “In total, 419 patients had diagnosed chronic atrial fibrillation...”

Major compulsory revisions:
1. More clinical information on the AF patient sample is not available in this study, as it merely focused on the anticoagulation control. Consequently the lack of clinical information is acknowledged in the Discussion section (last paragraph, first sentence) as follows: “The major limitations of this study are that it is rather small, the lack of clinical features regarding potential contraindications to anticoagulation, and the lack of information about the presence or absence of risk factors for stroke.”
2. We have clarified what we mean by “chronic atrial fibrillation” in the Method section, second paragraph as follows: “The diagnosis of chronic atrial fibrillation was based on a clinical diagnosis recorded by the GP, including persistent (i.e. en episode of atrial fibrillation that has not reverted spontaneously to sinus rhythm) and permanent atrial fibrillation (i.e. when attempts at restoration of sinus rhythm have failed or where the probability of successful cardioversion is considered so low that no attempt is made) [27]. Chronic atrial fibrillation is distinguished from ‘Paroxysmal tachycardia’ (code
I47-, including episodes of atrial fibrillation which are self-terminating) in the current classification.” A new reference on this matter is added (Cobbe SM 1997).

3. The estimates given in the Background section for fatal or major bleeding complication are corrected, and the reference is changed (to Kalra et al 2000) as follows: “The number of fatal or major bleeding complications in clinical practice is about 1.7% per patient-year [14].”

4. Our use of linear interpolation includes only values separated by 8 weeks or less, and this is clarified in the Method section as follows: “The time spent in the INR target range was estimated using linear interpolation [30], which assumes that the INR between two consecutive measurements varies linearly, including only INR values obtained at intervals of eight weeks or less.”

5. The proportion of cases 65 years of age or older in different groups is clarified in the Result section, first paragraph, as follows: “The age group 65 years or older accounted for 91.6% of patients with CAF, and 3.35% in the population.” Further the denominator for patients starting anticoagulation is clarified, at the end of the same paragraph, as follows: “The number of patients who started warfarin treatment for CAF at the participating PHC centres was 54, accounting for 25.6% of patients with CAF who were not on warfarin treatment, and for 0.07% of the population.”

6. The prevalence of CAF with increasing age is commented on in the first paragraph in the Results section as follows: “The prevalence of CAF increased with increasing age, from 0.19% in the age group 45-64 years, to 5.59% in the age group 85 years or older.” Further, the declining use of warfarin with older age is commented on in the same paragraph as follows: “The proportion treated with warfarin was 50.4%, declining from 85.7% in the age group 45-64 years, to 18.8% in the age group 85 years or older.” The findings on prevalence of CAF and increasing age are commented on in the Discussion section, second paragraph: “.....The relationship we found between prevalence and age is in accord with findings in similar studies.” The findings on the declining use of warfarin with older age are commented on in the Discussion section, third paragraph: “The declining use of warfarin with older age was somewhat more marked in our study compared to findings in similar studies [2, 16].”

7. We have acknowledged our estimates of CAF in the Discussion section, second paragraph: “...The prevalence figures for CAF in our study (0.6%, and 3.4% in 65+) are lower than in the studies mentioned above (0.9-1.2%, and 4.7-5.9% in 65+) [1-3], especially in patients 75 years or older, where our figures are significantly lower. This suggests that there may be an underdiagnosis of CAF in our study, or a selection bias in the types of patients seen in PHC.” Our statements on whether 50% treatment is likely the maximum of eligible patients is rewritten as follows: “Our figures may therefore approach what can be achieved in everyday clinical practice. However, the extent to which these figures can be improved is uncertain, since the number of patients eligible for anticoagulation is not known in our study.”

8. New references have been added and the Discussion section now includes 30 references in the text (18 different references). There are in total 32 references in the manuscript.